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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SHEILA MCCABE JORDAN,** **AKA SHEILA MARIE MCCABE** **2643 East Snowfield Street** **Brea, CA 92681** **Registered Nurse License No. 350034** Respondent.	Case No. 2011-1006 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about September 30, 1982, the Board of Registered Nursing issued Registered Nurse License Number 350034 to Sheila McCabe Jordan, aka Sheila Marie McCabe (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2012, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811, subdivision (b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 482 of the Code states:

"Each board under the provisions of this code shall develop criteria to evaluate the rehabilitation of a person when:

". . . .

"(b) Considering suspension or revocation of a license under Section 490.

"Each board shall take into account all competent evidence of rehabilitation furnished by the applicant or licensee."

8. Section 490 of the Code provides, in pertinent part, that a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued.

9. Section 493 of the Code states:

"Notwithstanding any other provision of law, in a proceeding conducted by a board within the department pursuant to law to deny an application for a license or to suspend or revoke a license or otherwise take disciplinary action against a person who holds a license, upon the

ground that the applicant or the licensee has been convicted of a crime substantially related to the qualifications, functions, and duties of the licensee in question, the record of conviction of the crime shall be conclusive evidence of the fact that the conviction occurred, but only of that fact, and the board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, and duties of the licensee in question.

"As used in this section, "license" includes "certificate," "permit," "authority," and "registration."

10. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

". . . .

"(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof.

". . . ."

11. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

". . . .

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to

himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

"(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.

". . . ."

REGULATORY PROVISIONS

12. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

13. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

14. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

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"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

15. California Code of Regulations, title 16, section 1444, states:

"A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

"(a) Assaultive or abusive conduct including, but not limited to, those violations listed in subdivision (d) of Penal Code Section 11160.

"(b) Failure to comply with any mandatory reporting requirements.

"(c) Theft, dishonesty, fraud, or deceit.

"(d) Any conviction or act subject to an order of registration pursuant to Section 290 of the Penal Code."

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16. California Code of Regulations, title 16, section 1445, states:

". . . .

"(b) When considering the suspension or revocation of a license on the grounds that a registered nurse has been convicted of a crime, the board, in evaluating the rehabilitation of such person and his/her eligibility for a license will consider the following criteria:

"(1) Nature and severity of the act(s) or offense(s).

"(2) Total criminal record.

"(3) The time that has elapsed since commission of the act(s) or offense(s).

"(4) Whether the licensee has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against the licensee.

"(5) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

"(6) Evidence, if any, of rehabilitation submitted by the licensee."

COSTS

17. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

18. From June 2003 until May 2004, Respondent worked as the Director of Nursing at Angels Hospital in Brea, California. Angels Hospital was licensed as a long term acute care hospital, which specialized in service to seniors, nursing home patients, and others with serious medical problems. As the Director of Nursing, it was Respondent's responsibility to:

a. Supervise all registered nurses, direct and coordinate all nursing activities in the delivery of patient care;

b. Plan, organize and schedule specialist nurses to various clinical departments;

c. Develop and initiate quality standards in nursing functions;

d. Monitor and supervise the functions of all nurses in a hospital setting;

e. Strategize on-going performance improvement issues in all nursing activities; and

f. Ensure compliance of state or federal nursing practice guidelines or laws.

19. In June 2003, at the time Respondent first became Director of Nursing at Angels Hospital, no patients had been yet admitted. While Respondent served as Director of Nursing, however, the hospital did receive licensure, and began to admit patients. Respondent knew the hospital was not paying or honoring the contracts with the registry service supplying the nursing staff to the hospital which resulted in constant shortage of nursing staff at the hospital. Respondent believed that she did not have enough nursing staff to safely meet the needs of patients at Angels Hospital. Respondent knew that the hospital was also not paying medical supply vendors who, in turn, stopped delivering medical supplies to the hospital. This resulted in a lack of medical supplies at the hospital, including ventilator, I.V., and catheter tubing. Because of the medical supply shortage, the hospital implemented a practice of changing tubing only when it was visibly soiled or contaminated. This practice correlates with higher infection and morbidity rates. Respondent complained to the hospital administration about the nursing staff shortage, the medical supply shortage, and the lack of an on-duty facility physician. Respondent did not, however, make a complaint to the Department of Health Service that Angels Hospital was failing to provide appropriate patient care. When Respondent later learned that a staff member reported the facility to the Department of Health Services, she reported the staff member to administration at the hospital. In June 2004, Angels Hospital was officially shut down following an investigation by the Department of Health Services.

Patient BR

20. In January 2004, patient B.R. was admitted to Angels Hospital to receive long term acute ventilator care, and specifically for the purpose of being weaned off the ventilator. B.R. was totally dependent on the staff at Angels Hospital for her health, safety, and medical care.

21. On March 12, 2004 at 7:00 a.m., patient B.R.'s heart rhythm showed ventricular tachycardia on the heart monitor. Ventricular tachycardia is an abnormal heart rhythm. Because of the ventricular tachycardia, BR suffered respiratory distress, and difficulty breathing. There was no documentation that the on-call physician was called about patient B.R.'s changed medical

condition. B.R. then suffered cardiac arrest. Cardiac arrest is a condition in which the heart stops, and breathing ceases. When a patient suffers cardiac arrest, Code Blue is called indicating that the patient needs immediate resuscitation.

22. The Code Blue policy and procedure at Angels Hospital implemented in March 2003, and in effect during Respondent's tenure as Director of Nursing, provided that "House Supervisor/designee designates unit secretary or other appropriate individual must call the patient's private physician" during a Code Blue. Angels Hospital posted a "House Physician Schedule" that listed the physician on call 24 hours a day. On March 11, 2004, there was a note posted at Angels Hospital to all nursing staff directing them in the event of an emergency to not call 911, but the House Physician.

23. On March 12, 2004, at 7:05 a.m., the Code Blue was called. According to the Code Blue record, the House Supervisor, a respiratory therapist, and registry nurses were present during the patient's resuscitation effort. At 7:22 a.m., paramedics attended to patient B.R.'s emergency needs. At 7:45 a.m., after resuscitation efforts failed, patient B.R. was pronounced dead after the paramedics consulted with a local acute care hospital emergency physician.

24. The registry nurses attending to patient B.R. did not have documented competency in Advanced Cardiac Life Support (ACLS) as there were no ACLS certificates in their personnel files at Angels Hospital.

Patient E.R.

25. On March 30, 2004, patient E.R. was admitted to Angels Hospital for long term acute care. Patient E.R. was totally dependent on staff for all activities of daily living and medical care. During his residence at Angels Hospital, patient E.R. received total parental nutrition from a central venous catheter. The central venous catheter was inserted on March 30, 2004.

26. The Angels Hospital nursing policy and procedure on "Care of Central Venous Catheter" stated that non-occlusive dressing over the catheter site must be changed every 24 hours and occlusive dressing was to be changed every 72 hours. Central line dressing, if not changed in a timely manner, can cause infection and sepsis. Patient E.R.'s central venous

catheter was not changed for a period of 10 days. On April 9, 2004, patient E.R. died due to pneumonia, kidney failure, sepsis, and shock.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

27. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) of the Code in that Respondent was grossly negligent in her duties as director of nursing, as set forth in paragraphs 18 through 26, which are incorporated here by this reference. As the Director of Nursing for Angels Hospital, Respondent repeatedly engaged in acts of negligence as follows:

a. Respondent failed to ensure that the hospital had an in-house physician to attend to patient emergencies;

b. Respondent failed to ensure Angels Hospital contracted with a nearby acute care hospital to ensure that patients were transferred out if a patient's condition worsened;

c. Respondent failed to implement a safe Code Blue nursing policy and procedure;

d. Respondent failed to ensure that the registry nurses working at Angels Hospital completed ACLS training;

e. Respondent failed to ensure that the hospital had adequate medical supplies, including catheter tubing;

f. Respondent failed to ensure that the nursing policies and procedures for replacing catheter tubing at Angels Hospital were being implemented by the nursing staff; and

g. Respondent failed to report Angels Hospital to the Department of Health Services when she determined that patient safety was being compromised by inadequate medical and nursing staff, and the shortage of medical supplies.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

28. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) of the Code in that Respondent was incompetent in performing her duties as director of nursing, as set forth in paragraphs 18 through 27, which are incorporated here by this reference.

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THIRD CAUSE FOR DISCIPLINE

(November 30, 2005 Criminal Conviction for DUI on June 12, 2005)

29. Respondent is subject to disciplinary action under sections 490 and 2761, subdivision (f), of the Code in that Respondent was convicted of a crime that is substantially related to the qualifications, functions, and duties of a registered nurse. The circumstances are as follows:

30. On or about November 30, 2005, in a criminal proceeding entitled *People v. Sheila McCabe Jordan, aka Sheila Maria McCabe*, in Orange County Superior Court, case number 05NM10299, Respondent was convicted on her plea of guilty of violating Vehicle Code section 23152, subdivision (a), driving under the influence of alcohol, a misdemeanor; Vehicle Code section 23152, subdivision (b), driving with blood alcohol .08% or more, a misdemeanor; and Penal Code section 242, battery, a misdemeanor. Respondent admitted that her blood alcohol concentration was .28% and that she used force against her son, hereafter referred to as "S". An additional count of violating Penal Code 273a, child endangerment, a misdemeanor, was dismissed pursuant to a plea agreement.

31. As a result of the conviction, on or about November 30, 2005, Respondent was sentenced to 3 years informal probation, ordered to pay various fines and fees, and attend a 9 month Level 2 First Offender Alcohol Program, 3 Alcoholics Anonymous meetings per week, and a Mother's Against Drunk Driving Victim's Impact Panel.

32. The facts that led to the conviction are that on or about June 12, 2005, at approximately 6:54 p.m., officers with the Brea Police Department were called to a fire station about a traffic collision involving a possible drunk driver. The firefighters told the officers that they were in the fire station when they heard a noise outside. One of the firemen went outside and saw that a vehicle had hit a sign post on the side of the fire station. This fireman walked toward the vehicle and saw S, Respondent's minor son, get out of the car and talk on his cell phone. The fireman heard S say, "She's drunk." Respondent, the driver of the vehicle, yelled at S to get back into the car. When S was partially in the vehicle, Respondent drove forward, which caused S to jump out of the vehicle. The fireman told Respondent to turn off the car, and he took the keys from her. He smelled alcohol on Respondent's breath and called the police.

33. When the officer arrived, he also smelled alcohol on Respondent's breath. Respondent's eyes were bloodshot and watery, and her speech was slow and slurred. She had been drinking beer and scotch. The officer then conducted field sobriety tests. The first was the alphabet test, wherein Respondent was supposed to say each letter slowly and clearly. During the first attempt of this test, she left out letters "A" through "E." During her second attempt, she said the letters "A" through "M" quickly, stopped, and began crying. She did not want to continue the test. The officer also gave the heel-to-toe test and Respondent had three to four inch gaps in between her steps. Respondent was then arrested.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Use of Alcohol in a Dangerous Manner)

34. Respondent is subject to disciplinary action under section 2762, subdivision (b) of the Code in that on or about June 12, 2005, as described in paragraphs 29-33, above, Respondent used alcohol beverages to an extent or in a manner that was potentially dangerous and injurious to herself and to others, in that she operated a motor vehicle with significantly high blood alcohol concentration.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Conviction of Alcohol-Related Criminal Offense)

35. Respondent is subject to disciplinary action under section 2762, subdivision (c) of the Code in that on or about November 30, 2005, as described in paragraphs 29-33, above, Respondent was convicted of a criminal offense involving the consumption and/or self-administration of alcohol, which constitutes unprofessional conduct.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 350034 issued to Sheila McCabe Jordan, aka Sheila Marie McCabe;

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2. Ordering Sheila McCabe Jordan, aka Sheila Marie McCabe, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: June 28, 2011

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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